IN THE MATTER OF PETITIONS FOR DECLARATORY RULING

Parties:	*	
	*	
Injured Workers' Insurance Fund	*	**Potomac Valley Orthopaedic Associates**
	*	
	*	
CareFirst Blue Cross Blue Shield	*	**Robert G. Loeffler, M.D. and Jeffrey A.**
	*	**Abend, M.D. Orthopaedic Associates,**
	*	**P.A.**
Delmarva Orthopaedic Clinic	*	
	*	**M-S HC, LLC**
	*	
Robinwood Orthopaedic Specialty	*	**Greater Chesapeake Orthopaedic**
Center, P.A.	*	**Associates**
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DECLARATORY RULING NO. 2006-1

INTRODUCTION

This Declaratory Ruling arises out of two formal petitions, separately filed by CareFirst BlueCross BlueShield and The Injured Workers' Insurance Fund. These petitions ask the Board for a ruling on the propriety under the Maryland Self Referral Law of referrals made by physicians for MRI scans when that physician has a financial interest in the performance of that scan.

On March 22, 2006, the Board voted to grant both petitioners' original written requests for Declaratory Rulings under COMAR 10.32.16.03A, contingent on the their completion of the appropriate form as required by the regulations. Both petitioners completed the required form on April 28, 2006. On June 6, 2006, the Board, as required

by the regulations, set out in writing a procedural ruling and timetable for consideration of the petition.[1]

On June 30, 2006, the Board invited all of the orthopaedic practices whose referrals had been questioned by either CareFirst or IWIF to join in the Declaratory Ruling. On July 24, 2006, two of the medical practices named by the insurance companies, M-S HC, LLC ("Multi-Specialty Health Care" or "Multi-Specialty") and Greater Chesapeake Orthopaedic Associates ("Greater Chesapeake") submitted formal petitions to join the Declaratory Ruling. The Board accepted the petitions of Multi-Specialty and Greater Chesapeake, and those two entities were granted status as parties to the case. On August 2, 2006, the remaining four medical practices declined to join the case as parties. Subsequently, after the Board staff issued its Proposed Declaratory Ruling on September 7, 2006, the remaining four medical practices petitioned to be made parties to the case. The Board granted that request. The Board is authorized to issue this Declaratory Ruling pursuant to the State Government Article §§10-301 *et seq.* and the Code of Maryland Regulations, COMAR 10.32.16.

RECUSAL

The Chairperson of the Board of Physicians, Dr. Harry Knipp, recused himself from this Declaratory Ruling process and has taken no part in this decision, nor has Dr. Knipp been involved in any of the procedural rulings.

[1] Andrea B. Cherenzia, Director, Special Investigations at CareFirst BlueCross BlueShield ("CareFirst") first requested such a ruling in writing on January 15, 2004. On December 6, 2005, Lesley J. Tompkins, Fraud Examiner at The Injured Workers' Insurance Fund ("IWIF") made a similar request. Neither insurance company completed the required form until April 28, 2006.

BACKGROUND

The Board has collected medical reports, MRI reports, and physician billing records originating from orthopaedic practices named by CareFirst or IWIF. The Board has also collected publicly available information and has conducted interviews. Some of the parties have also submitted affidavits and other factual materials, as well as legal arguments. Since this is a Declaratory Ruling process and not a disciplinary proceeding, the purpose of the fact-collecting process was simply to ascertain what type of fact patterns actually exist in the community in sufficient numbers to make a declaratory ruling worthwhile and to gather sufficient facts to make sure that the Board can interpret the law in a real-world context. There has been no effort therefore to "test" these facts through an adversarial evidentiary process. Nevertheless, this Declaratory Ruling is intended to be sufficiently grounded in reality to cover a number of situations that actually exist and thus to be of use to the parties in dealing with each other.

CareFirst and IWIF originally questioned the propriety of referrals made by physicians in a total of eight medical practices; in the cases of two medical practices, however, their activities were of a different nature than the others and did not implicate issues raised by the original parties or of current interest to the Board. These two medical practices were eliminated from the Board's investigation.

Each of the parties other than the two insurance companies are medical practices whose physicians do make referrals, or in the past have made referrals, for MRI scans on MRI equipment that is owned or leased by the same practice. Four of these practices, Robinwood Orthopaedic Specialty Center, P.A., Delmarva Orthopaedic Clinic, Potomac Valley Orthopaedic Associates, Chartered, and Robert G. Loeffler, M.D. and Jeffery A.

Abend, M.D. Orthopaedic Associates, P.A., have publicly admitted that physicians within their practices regularly refer patients to MRI equipment that is owned or leased by their respective practices.[2] One of these parties, Greater Chesapeake Orthopaedic Associates, LLC, states that it was engaged in this practice in the past but has now largely stopped doing so.

Example cases reviewed by the Board

The Board has examined numerous individual patient cases and, from those cases, has set out below seven example cases. Numerous cases were examined so that the Board could determine if there were recurrent fact patterns and to help ground any ruling in the "real world" medical context. Patient's real names are not used in the Board's discussion of any of these example cases. At the request of some of the medical practices, the Board also will not use the full name of the referring physician involved.

1. Dr. GS's referral of "G" for a scan on MRI equipment owned by Robinwood Orthopaedic Specialty Center.

According to an application submitted by Robinwood to register its corporate name, Dr. GS is a stockholder of Robinwood. Also, according to admissions made by Robinwood in *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, it owns MRI equipment and uses it to provide MRI scans to all three of its offices.

According to records originating from Robinwood, Dr. GS saw Patient G on 11-12-2002, during which visit he ordered Patient G to receive an MRI of his right shoulder. The records do not reveal at which office Patient G was seen.

Records of the MRI indicate that the MRI was taken at a Robinwood office on 1-3-2003, and was later read by an off-site radiologist group called Franklin & Seidelmann.

[2] The Board received this information from a Complaint filed in the Circuit Court for Baltimore City on behalf of 14 medical practices, including the 4 named above. *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, Case No. 24-C-06-003146OG. The complaint was ultimately dismissed.

The bill[3] for the MRI scan names Dr. GS as the supplying physician. The bill indicates the MRI scan was billed under Robinwood's address and Federal Tax Identification Number.

2. Dr. MS's referral of Patient J to MRI equipment leased by Delmarva Orthopaedic Clinic.

According to an application submitted by Delmarva Orthopaedic Clinic for the registration of its corporate name, Dr. MS is listed as a stockholder of Delmarva. According to admissions made by Delmarva in *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, it leases MRI equipment and uses it to provide MRI scans to all four of its offices.

According to records originating in Delmarva, Dr. MS saw Patient J on 6-5-2003, during which time he ordered Patient J to receive an MRI of her right knee. He stated "I recommended that we consider an MRI of her knee. We are going to work on getting this setup."

Records of the MRI indicate that the MRI scan was taken at Delmarva's MRI equipment on 6-6-2003 and was later read by an off-site radiologist group called Franklin & Seidelmann.

The bill for the MRI scan names Dr. MS as the supplying physician; additionally the bill indicates the MRI scan was billed under Delmarva's billing address and Federal Tax Identification Number.

3. Dr. CM's referral of Patient Q to MRI equipment owned or leased by Multi-Specialty Health Care, LLC.

According to an application submitted by Multi-Specialty for registration of its corporate name, Dr. CM is a stockholder in Multi-Specialty. Also according to statements made on Multi-Specialty's website, it appears Multi-Specialty has a financial interest in the MRI equipment located at 6660 Bel Air Rd, Baltimore, Maryland 21206, and uses the equipment to provide MRI services for its patients. Multi-Specialty has eighteen office locations in seven counties in Maryland.

According to records obtained from IWIF[4], but created by Multi-Specialty, Dr. CM saw Patient Q on 12-6-2004, during which time he ordered "Q" to receive an MRI of his lower back. Dr. CM stated: "I have arranged for an MRI scan to be performed on Q's lumbar spine to rule out a centrally herniated lumbar disc as a cause of his persistent lower back pain..."

[3] The word "bill" as used in this document refers to the "Health Insurance Claims Form" or similar document submitted to an insurance company for payment.
[4] The term "IWIF" refers to the Injured Workers' Insurance Fund, a party to this case.

Records of the MRI indicate that it was taken at Multi-Specialty MRI located at Multi-Specialty's office at 6660 Bel Air Rd, Baltimore, Maryland 21206 on 12-14-04. According to the radiology report of the MRI, Dr. Sonja Schaffer read the MRI .

The bill for the MRI scan names Dr. CM as both the referring and supplying physician; additionally, the bill indicates the MRI scan was billed under Multi-Specialty Health Care's billing address and Federal Tax Identification Number.

4. Dr. SM's referral of Patient JJ to MRI equipment owned by Potomac Valley Orthopaedic Associates.

According to statements made by Potomac in *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, Potomac owns MRI equipment and uses it to provide MRI scans for its four office locations. Additionally, Potomac Valley Orthopaedic Associates is comprised of 13 physicians. According to Potomac's website, Dr. SM is one of its 13 physician members.

According to records obtained from IWIF, but created at Potomac, Dr. SM saw Patient JJ on 7-14-2005, during which time he ordered Patient JJ to receive an MRI of his shoulder. Dr. SM stated: "I have asked for an MRI and reevaluation of the shoulder."

Records of the MRI indicate that it was taken at Potomac Valley's MRI located at Potomac's office at 10700 Charter Drive #120, Columbia, MD 21044 on 8-29-05. According to the radiologist report of the MRI, Dr. Mukul Das of Community Radiology Associates read the MRI.

The bill for the MRI names Dr. Mukul K. Das of Community Radiology Associates as the supplying physician; however, the MRI scan was billed under Potomac's billing address and Federal Tax Identification Number.

5. Dr. JO's referral of Patient V to MRI equipment owned by Greater Chesapeake Orthopaedic Associates.

According to records obtained by the Maryland Department of Assessment and Taxation, Dr. JO is a corporate officer and member of Greater Chesapeake. Dr. JO has acknowledged that he has a beneficial interest in Greater Chesapeake.

According to records obtained from CareFirst, but created at Greater Chesapeake, Dr. JO saw Patient V on 7-16-2004, during which time he ordered Patient V to receive an MRI of his right knee. Dr. JO stated: "I

also gave him a prescription to obtain an MRI. If he is still symptomatic in one month he will obtain an MRI to rule out a lateral meniscal tear."

The radiologist report of the MRI states that it was taken at Greater Chesapeake on 8-25-2004 and read off-site by Dr. Carlton C. Sexton of American Radiology Services, Inc.

The bill for the MRI names Dr. JO as the referring physician and Dr. LM as the providing physician. Dr. LM acknowledges being a member of Greater Chesapeake as well. The bill indicates the MRI scan was billed under Greater Chesapeake's billing address and Federal Tax Identification Number.

Greater Chesapeake acknowledges having a financial interest in the MRI equipment used for this referral, and that entity billed $1,668 for the MRI under its Federal Tax Identification Number.

6. Dr. RL's referral of Patient I to MRI equipment leased by Robert G. Loeffler, M.D. and Jeffery A. Abend, M.D., Orthopaedic Associates ("Orthopaedic Associates").

According to admissions made by Orthopaedic Associates in *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, it leases MRI equipment located in its office at 2101 Medical Park Drive, Silver Spring, MD 20902. Additionally, it appears probable that Dr. RL is a member of the practice.

Dr. RL saw Patient I on 1-30-2003. It appears that during this visit Dr. RL referred Patient I for an MRI of her ankle. Dr. RL's records of the visit could not be obtained by the Board, but the MRI report names Dr. RL as the referring physician.

The radiologist report of the MRI indicates that it was taken at Orthopaedic Associates' office location at 2101 Medical Park Drive, Silver Spring, MD 20902 and read off-site by Dr. Robert Rabiea at Franklin & Seidelmann.

The bill for the MRI scan names Dr. RL as the supplying physician. Additionally, the bill indicates that the MRI scan was billed under Orthopaedic Associates' billing address and Federal Tax Identification Number.

7. Dr. SW's referral of Patient F to MRI equipment owned by Robinwood Orthopaedic Specialty Center.

According to an application submitted by Robinwood to register its corporate name, Dr. SW is a stockholder in Robinwood Orthopaedic Specialty Center. Also, according to admissions made by Robinwood in *Maryland Patient Care and Access Coalition, Inc. et al. v. Board of Physicians*, Robinwood owns MRI equipment and uses it to provide MRI scans for its three office locations.

According to records originating from Robinwood Orthopaedic Specialty Center, Dr. SW saw Patient F on 5-12-2003, during which visit he ordered Patient F to receive an MRI of his right shoulder. Patient F had been previously referred to Dr. SW by Dr. Allen Ditto, a family practitioner, for orthopaedic consultation and treatment.

The office of Dr. Allen Ditto, after initially referring Patient F to Dr. SW, later received information that Dr. SW had ordered an MRI of Patient F's right shoulder. Dr. Ditto then signed a Maryland Uniform Consultation Referral Form. This is an insurance form required by CareFirst in its POS contracts. Dr. Ditto's signature on the form validates that the referral to Robinwood is an in-network referral, thus assuring that the patient will not be billed for any charges above the CareFirst rate. Dr. Ditto, however, is not required to, nor did he, exercise any medical judgment as to whether the MRI ordered by Dr. SW for Patient F's right shoulder was appropriate or necessary, nor did he see this patient for this purpose after Dr. SW ordered an MRI. The MRI scan was taken at Robinwood on 5-19-2003, and read by an off-site radiologist group called Franklin & Seidelmann.

The bill for the MRI scan names Dr. SW as the supplying physician. The bill indicates the MRI scan was billed under Robinwood's address and Federal Tax Identification Number.

These cases are representative of all the cases reviewed by the Board. These cases indicate that a common factual scenario exists among some Maryland orthopaedic practice groups with respect to referrals for MRI services. The common factual scenario is set out below. Additionally, the Board has found several relevant variations to the general fact pattern that occur frequently in Maryland. The Board will rule on those as well.

General Fact Pattern

A patient is seen by an orthopaedic physician who has a beneficial financial interest in the orthopaedic practice. The patient may have been referred to the orthopedist by another physician, or the patient may have come directly to the orthopaedic physician. The orthopaedic physician makes a referral for an MRI scan. The patient receives the MRI a few days or weeks later on an MRI machine that is owned and operated by, or leased by, the orthopaedic physician's practice. The MRI image may be read in-house or may be sent to an off-site radiologist to be read. An off-site radiologist may state his or her findings in a radiology report and forward the report back to the orthopaedic physician. The referring orthopaedic physician's practice submits a bill for the MRI as the provider of the MRI scan (though not necessarily as the provider of the interpretation of the scan).[5]

Additionally, the Board found the following variations to this fact pattern. The following are modified fact patterns which may also occur in significant numbers in this State.

VARIATION 1

Same as the general fact pattern, but the orthopaedic physician obtains a signed Maryland Uniform Consultation Referral Form from the patient's primary care physician after the orthopedic physician determined that the MRI was necessary, but before the MRI was actually conducted.

The primary care physician does not, between the time that the orthopaedic physician determines that the MRI is necessary and the time that the MRI was accomplished, see the patient for the purpose of determining if the MRI is necessary, nor does he or she exercise independent medical judgment as to whether the MRI is appropriate or necessary.

VARIATION 2

Same as the general fact pattern, but the orthopaedic physician names the primary care physician as the "referring physician" in the Health Insurance Claim Form.

The primary care physician does not, between the time that the orthopaedic physician determines that the MRI is necessary and the time that the MRI was accomplished, see the patient for the purpose of determining if the MRI is necessary, nor does he or she exercise independent medical judgment as to whether the MRI is appropriate or necessary.

[5] In these cases, the referring physician typically billed the patient, or the patient's insurance company, between $1,200 and $1,668 per MRI scan.

VARIATION 3

Same as the general fact pattern, but a physician who is an employee of the medical practice that provides the MRI scan evaluates the patient and orders the MRI to be done by that practice. The physician-employee does not have any beneficial interest in the medical practice.

ANALYSIS

The Purpose of the Self-Referral Law

The Maryland Self-Referral Law was enacted during the 1993 legislative session as House Bill 1280 (HB 1280). The Legislative history shows that HB 1280 was part of a statutory scheme designed to address two problems plaguing health care in Maryland: "access to health insurance and escalating health care costs." The legislative history file contains the following statement regarding the scheme of bills:

> Recent studies show that 16% of Maryland's population (approximately 650,000 people) have no health insurance coverage and the percentage of our gross national product spent on health care continues to rise at unacceptable levels. While we in Maryland have been successful in controlling our in-patient costs through the rate setting mechanism, the out-patient side has no similar cost controls.
>
> During the 1993 Session of the General Assembly several significant pieces of legislation [including House Bill 1280] were enacted in an attempt to address these problems.

House Environmental Committee file on House Bill 1280 (1993), General Assembly of Maryland.

The legislature believed physician self-referring was pervasive enough to have an adverse impact on health care costs generally. The Senate Economic and Environmental Affairs Committee reported in its analysis of House Bill 1280:

> Various studies have concluded that self-referrals contribute to higher health-care costs and unnecessary utilization of services. The bill is intended to eliminate the incentive for a health care provider to make referrals to a health care facility out of financial self-interest rather than for the benefit of the patient.

Bill Analysis, House Bill 1280, Senate Economic and Environmental Affairs Committee, 1993 General Assembly of Maryland.[6]

According to the testimony of the sponsor of House Bill 1280, self-referrals had been proved to be inherently conducive to abuse and overcharging:

> The evidence is overwhelming that these referral relationships result in abuse, overcharging and over-utilization. I've attached a list of relevant studies on this subject for your review. As you'll see, the evidence indicating abuse has been clearly and objectively demonstrated.

Testimony of Sponsor, Chairperson Del. Ronald A. Guns, before the Senate Economic and Environmental Affairs Committee, March 24, 1993.

The sponsor cited several studies that pinpointed several services that were commonly overutilized. It appears that imaging services, including MRI scans and CT scans, were found to be particularly vulnerable to such abuse.

> (1) The *New England Journal of Medicine* studied MRI scans and found that 38% of MRI scans prescribed by invested physicians were found to be medically inappropriate. (11/19/92);

[6] The federal self-referral law, 42 U.S.C. § 1395nn, commonly known as "Stark II," was passed a year later than HB 1280. The federal statute is significantly narrower than the Maryland Self Referral Law in that the federal law: (1) covers only physicians; and (2) covers only self-referrals of certain "designated health services."

(2) Radiation therapy was used substantially more frequently, and at a substantially higher cost, when the referring physician had a financial interest in the referral. (*New England Journal of Medicine*, 12/6/90)[7];

(3) Maryland and Pennsylvania physicians who had a financial interest in an imaging center ordered a greater number of such tests, and ordered more expensive tests than "non-invested" physicians. (United States General Accounting Office Study);

(4) There was a 13 to 45% increase in referrals by invested physicians than in comparably diagnosed patients seen by non-invested physicians, (United States Inspector General Finding).

Attachment to Testimony of Delegate Guns of March 24, 1993.

Finally, during the Senate floor debate concerning HB 1280, the floor leader on the bill, Senator Hollinger, explained why MRIs, CAT scans and radiation therapy were specifically excluded from the exceptions to HB 1280:

> All of the studies that have been done have shown that those three pieces of major medical equipment are where the most abuses have taken place.

Senator Hollinger also stated:

> Because they are very, very expensive pieces of equipment and the more expensive the equipment is the more people you've got to refer to it to pay for it.

See 89 Opinions of the Attorney General 10, 15-16 (January 5, 2004). (Quoting Senate floor debate concerning House Bill 1280 (1993) (third reading)).

There seems to be little question that the legislature intended by this bill to substantially restrict the practice of self-referring, especially self-referrals of MRI scans, CAT scans and radiation therapy services. The Self-Referral Law thus created a broad

[7] The U.S. Department of Health and Human Services also cited this study in its preamble to its proposed regulations to the federal self-referral law. HHS stated that the study found self-referring physicians obtained imaging examinations 4.0 to 4.5 times more often than the physicians who referred to an unrelated radiologist. *See* 63 Fed. Reg. 1676 (Jan. 9, 1998).

and pervasive prohibition against self-referrals not only by physicians (as did the federal law) but also all by all other health care providers. In addition, and again unlike the federal law, the Maryland prohibition covered every type of health care service.

The Maryland Self Referral Law first flatly bans any self-referral and any arrangement or scheme which has a principal purpose of accomplishing self-referrals:

> (a) *Prohibited referrals.* -- Except as provided in subsection (d) of this section, a health care practitioner may not refer a patient, or direct an employee of or a person under contract with the health care practitioner to refer a patient to a health care entity:
>
> (1) in which the health care practitioner or the practitioner in combination with the practitioner's immediate family owns a beneficial interest:
>
> (2) In which the practitioner's immediate family owns a beneficial interest of 3 percent or greater; or
>
> (3) With which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement ....
>
> (b) *Payment prohibited.* – A health care entity or a referring health care practitioner may not present or cause to be presented to any individual, third party payor, or other person a claim, bill or other demand for payment for health care services provided as a result of a referral prohibited by this subtitle.
>
> (c) *Applicability of subsection (a).* -- Subsection (a) of this section applies to any arrangement or scheme, including a cross-referral arrangement, which the health care practitioner knows or should know has a principal purpose of assuring indirect referrals that would have be in violation of subsection (a) of this section if made indirectly.

Md. Health Occ. Code Ann. § 1-302 (cited hereafter by section "§" only.)

Because the general rule is so broad and sweeping, numerous exceptions had to be made to accommodate situations in which there is no significant threat of overutilization.

Each of the three exceptions at issue in this case generally permits referrals where there is little incentive for a physician to self-refer for financial gain.[8]

This Declaratory Ruling will deal with the three exceptions contained in § 1-302 (d)(2), (d)(3) and (d)(4), as they apply to the fact patterns developed in this case. In interpreting these exceptions, the Board has complied with the following statutory construction rules. The statute should be interpreted "with reference to the purpose to be accomplished." *State v. Fabritz*, 276 Md. 416, 421 (1975). The statute must be considered "in its entirety, in the context of the purpose underlying its enactment." *Id.* The interpretation must seek to harmonize the statute as a whole. *In re Steven K.*, 289 Md. 294, 298 (1975). Language of an individual part of a statute must be interpreted "in relation to all its provisions," and the interpretation must "harmonize individual selections as parts of a whole." *Burghout v. Mayor and City Council of Baltimore*, 325 Md. 311, 317 (1992). The statute must be interpreted "as a whole, so that no word, clause or phrase is rendered surplusage, superfluous, meaningless or nugatory." *Lawson v. State*, 389 Md. 570, 583 (2005).

Although, as the parties argue, the statute is "extraordinarily complex," this does not in the Board's opinion relieve the Board of its responsibility to interpret it. The statute should be interpreted consistently with its overall purpose, taking into account all parts of the statute and without rendering any particular part of the statute meaningless or superfluous.

[8] This statement refers to the exceptions at issue in this case, *i.e.*, the exceptions found at § 1-302 (d) (2), (3) and (4). There are other exceptions that arise out of completely different concerns. For example, where patients might otherwise be deprived of a needed health service, the bar to self-referral does not apply. § 1-302 (d) (5).

Each of the exceptions at issue will be discussed below in relation to each other and to the overall purpose of the Self Referral Law.

1. <u>Exception §1-302(d)(2)</u>

> (d) The provisions of this section do not apply to:
>
> (2) A health care practitioner who refers a patient to another health care practitioner in the same group practice as the referring health care practitioner.

§1-302(d)(2).

The Board finds that the exception contained in (d)(2)[9] was intended to create an exception for referrals that transfer *a patient*, permanently or temporarily, from one health care practitioner in a group practice to another.

If this exception did not exist, the Self Referral Law would prohibit a physician from referring a patient to another member of the group practice in any situation, even when a physician is simply going out of town and refers a patient temporarily to his or her partner. Obviously, that situation does not pose a major threat of overutilization of health care services. Referral of a patient to a member of one's own group may serve the patient well without a significant danger of overutilization caused by financial self-interest on the part of the referring physician. On the other hand, when a physician orders a specific service or test from a group member, especially an expensive service or test on a very expensive machine that is being leased or financed by the practice, there may be a substantial financial incentive for overutilization.

The Board notes that exception (d) (2) speaks of a situation in which a physician "refers a patient" to another member of the group practice. There is no mention of

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[9] The Board will refer to the exceptions set out in Md. Health Occ. Code Ann. § 1-302 (d)(2), (3) and (4) as "(d)(2)," "(d)(3)" and "(d)(4)," respectively.

"services or tests." The Board finds that the intention is to exempt only situations where the physician refers *the patient* to another member of the group practice, but not where the physician continues treating the patient as his or her own patient and simply orders specific "tests" or "services" from another member of the group. The Board concludes that exception (d) (2) simply allows the transfer of the professional responsibility for the patient's continued care, including professional decision-making about the course of that care, to another physician within the same group practice. Exception (d) (2) thus does not exempt referrals for specific "services or tests" already chosen by the referring physician.

Some of the parties have argued that, because the term "referral" is defined broadly in §1-301 (l), the term "refers a patient" in (d)(2) must also be defined that broadly. The Board disagrees. "Referral" is indeed broadly defined in accordance with the legislature's intent to make a broad prohibition of self referrals. In making the exceptions to this broadly defined prohibition, however, the legislature intended to set out a specific subset of such referrals which would be permitted. The bare words "refers a patient" in (d)(2) do not necessarily encompass every type of referral. The Board finds that this phrase means the referral of, as the sentence reads, the "patient." In neither of the other two exceptions do these bare words appear. This different language was used, the Board concludes, in order to distinguish it from (d) (3) and (d) (4), both of which use the words "services or tests." Since the words "services or tests" are not used in (d) (2), the Board concludes that (d) (2) was not intended to apply to services or tests that the referring physician has already determined are necessary.

In addition, reading the word "tests" into (d) (2) would contradict (d) (4) (i) (2). The latter provision permits certain "in-office" services and tests. Under that provision, however, extensive additional conditions must be met before services or tests may be performed within the practice. These additional conditions in (d)(4)(i)(2) would contradict (d)(2) if (d)(2) were interpreted to permit unconditional referrals for tests and services within the group. At the very least, interpreting (d)(2) as permitting unconditional referrals of tests and services within the group would render the additional requirements of (d)(4)(i)(2) as meaningless surplusage. Different language (the word "patient" without any reference to "services and tests") was used in (d) (2), the Board concludes, in order to speak of a different situation and achieve different results without undercutting the requirements of (d)(4)(i)(2). The only way to read (d)(2) and (d)(4)(i)(2) together so that they both have meaning is to read (d) (2) to apply to the referral to a physician in the same group practice of a *patient*, but not for "services" or "tests" already determined necessary by the referring physician. This interpretation complies with the actual wording of (d) (2), does not conflict with (d) (4) (i) (2), establishes a necessary exemption in a situation in which there is not a financial incentive for overutilization but at the same time does not create a loophole so large that it swallows up the other exceptions. This interpretation thus harmonizes these exceptions and at the same time is in accordance with the overall purpose of the Self Referral Law to prevent self-referrals in situations where the opportunity for financial gain from referrals brings about a risk of overutilization.[10]

[10] This is not to say that it is impossible for a physician to attain any financial gain whatsoever from a referral permitted under (d)(2), but that the financial gain in most cases may be attenuated and may not pose a significant threat of overutilization.

Some of the parties argue that the "group practice" exception in (d)(2) protects against overutilization because group practice members are "accountable to one another" and "subject to scrutiny" that will prevent overutilization. There is no indication that the legislature had that belief. Members of a group practice would likely have neither the opportunity nor the inclination to question each other's referrals for possible overutilization, and in fact each member of a group practice would have a strong financial interest in keeping an MRI machine utilized and thus paid for. This situation would actually create an obvious and concrete incentive to overutilize.

Greater Chesapeake and Multi-Specialty argue that "health care service" is broadly defined as "medical procedures, tests and services" in §1-301 (i), and that the legislature did not mean to differentiate in (d)(2), (d)(3) and (d)(4) between referral of a patient and a referral for tests and services. The Board disagrees with this argument. The Board believes that the legislature was using its words in (d)(2), (d)(3) and (d)(4) to indicate a particular subset of the totality of "health care services." The use of the word "tests" in (d) (3) is illustrative. If the legislature were using the term "health care services" as broadly as is set out in § 1-301 (i), the legislature would not have added the word "tests" to (d) (3), because "tests" are already included in the broader definition of "health care services" in §1-301 (i). The phrase used is thus somewhat grammatically ambiguous in this context, and an interpretation in keeping with the overall intention of the statute is called for. The Board concludes that the legislature intended to define these exceptions narrowly, especially in the light of its expressed concern with the past abuses of self-referred MRIs.[11] The Board's interpretation takes into account the otherwise-

[11] The Board also notes than an exception allowing certain group practices to self-refer MRIs passed the House of Delegates but was ultimately removed from the bill. *See*, 89 Op. Att'y Gen. at 15.

superfluous word "tests" and effectuates the intent of the legislature. *See also* 89 Op. Att'y Gen 10 (2004) (Allowing MRI referrals within group practices "would render meaningless the precise limitations the Legislature created in § 1-302 (d)(4)").

Applying this interpretation of (d)(2) to this case, MRI scans are services and tests. A referral for an MRI scan is a referral for a service or test, not a referral of a "patient" within the meaning of (d) (2). MRI scans are thus not covered at all by exception (d) (2), because that exception deals with referrals of a patient and not with referrals for "services or tests." The referrals for MRI scans made by the physicians in this case, to the extent that they result in an MRI scan in which the referring physician has a beneficial interest, are not exempted from the Maryland Self Referral Law by exception (d) (2).[12]

2. <u>Exception § 1-302 (d)(3)</u>

> (d) The provisions of this section do not apply to:
>
> > (3) A health care practitioner with a beneficial interest in a health care entity who refers a patient to that health care entity for health care services or tests, if the services or tests are personally performed by or under the direct supervision of the referring health care practitioner.

§ 1-302 (d) (3).

The Board finds that the exception contained in §1-302(d)(3) was intended to create an exemption for referrals of a patient for services or tests to a health care entity that is outside of the referring physician's practice, even if the referring physician holds a

[12] If (d) (2) did apply to services and tests, the exception would apply only to a "group practice" as defined in the Self-Referral Law. That definition includes the requirement that members of the group practice their profession "through the joint use of shared office space, facilities, equipment and personnel." §1-301 (f)(1). This term could be read to mean that all of the practitioners in the group must be able to use the equipment that the others in the group use, and/or that all of the practitioners in the group must in fact use that equipment. The Board, however, does not have to reach the issue of whether these medical practices meet the definition of "group practice" in § 1-301(f)(1) , because the Board has found that (d)(2) does not apply to "services or tests," even within a group practice.

beneficial interest in the outside entity, so long as the physician is personally present within the treatment area when the service is performed and either personally providing the service or directly supervising that service.

The term "health care entity" in exception (d) (3) does not include the referring physician's own practice and thus does not include a referral to one's own group practice for services or tests. A different exception, exception (d) (4), specifically deals with in-office referrals, and that exception places numerous restrictions and qualifications on "in-office" referrals. These restrictions and qualifications placed on in-office referrals by exception (d) (4) would be completely superfluous if (d) (3) were interpreted to also govern in-office referrals.[13] Since (d) (3) should not be interpreted to make any part of (d) (4) meaningless or superfluous, the Board finds that (d) (3) does not include in-office referrals.

The legislative history also makes clear that (d) (3) deals with referrals to an outside entity. The American Medical Association's ethical position statement, upon which (d) (3) was based, states:

> In general, physicians should not refer patients to a health care entity <u>outside</u> their office practice at which they do not provide care or services when they have an investment interest in that facility.

AMA Policy Statement on Self-Referral in House Environmental Matters Committee file (emphasis added).

The Medical and Chirurgical Faculty of Maryland testified that "physicians should not refer patients to a health care facility <u>outside</u> their office practice ...."

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[13] For example, for an in-office referral to be permitted under (d) (4), the service must be "basic," "routinely provided" and "provided in the same building." *See* § 1-301 (k) (defining "in-office ancillary services" as "basic" and "routine") and (d) (4) (ii) (requiring the services to be provided in the "same building"). All of these requirements of (d) (4) would be rendered superfluous if (d) (3) were interpreted to deal with in-office referrals.

Testimony of Paul A. Stagg, M.D. before the House Committee on Environmental Matters, February 24, 1993 (Emphasis added; citing the AMA Policy statement).

> The House Environmental Matters Committee reported that:
>
> the American Medical Association adopted a policy stating that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility.

Floor Report on House Bill 1280, House Environmental Matters Committee. (Emphasis added.) That Committee then reported to the House floor:

> House Bill 1280 is consistent with the American Medical Association's policy on self referral.

House Floor Speech prepared by the Environmental Matters Committee.

Again, before the Senate, the testimony was to the same effect: (1) that the exception was meant to apply to outside entities; and (2) that the bill was consistent with the AMA's position. *See*, for example, the testimony of the Medical and Chirurgical Faculty of Maryland before the Senate Economic Affairs Committee ("HB 1280 ... would prohibit patients from referring patients to outside facilities in which they have an interest") (emphasis added) and the testimony of Johns Hopkins Hospital, Francis Scott Key Medical Center, Baltimore County General Hospital and the further testimony of the Medical and Chirurgical Faculty of Maryland (all stating that the bill is consistent with the AMA's policy).[14]

Exception (d) (3) appears to parallel the AMA policy that the legislature intended to implement. First, the AMA policy applies only where the physician has an investment interest; likewise (d)(3) only applies where the physician has a beneficial interest.

[14] In addition, numerous letters written to then governor William Donald Schaefer in support of his signing the bill state the opinion that the bill is consistent with the AMA policy.

Second, the AMA policy requires the physician to "directly render services" at the outside entity; likewise, (d)(3) requires the physician to personally perform or directly supervise the service or test while present at the entity." Exception (d)(3) was intended to parallel the AMA policy; it therefore creates an exception that permits a physician in certain circumstances to refer patients to an outside entity in which he or she holds a beneficial interest.[15] Exception (d) (3) does not, however, permit a physician to refer to his or her own in-office practice.

MRIs are "services or tests." Exception (d) (3), however, applies only to referrals for services or tests to outside entities and not to in-office referrals within the group practice of the referring practitioner. Exception (d) (3) thus does not apply to in-office referrals by physicians for MRI scans to be provided by their own practices.[16]

3. Exception (d)(4)

> (d) The provisions of this section do not apply to:
>
> (4) A health care practitioner who refers in-office ancillary services or tests that are:
>
> (i) Personally furnished by:
> (1) The referring health care practitioner;
> (2) A health care practitioner in the same group practice as the referring health care practitioner; or
> (3) An individual who is employed and personally supervised by the qualified referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner;

[15] The Attorney General has opined that exception (d)(3) applies to outside entities only. *See* Op. Att'y Gen. 49 (2006).

[16] Additional issues could arise regarding whether the referring physician has provided "direct supervision." *See* §1-301(d). Some of the parties have submitted evidence on this issue, stating that their physicians have the knowledge and skill to supervise the operation of these machines. The Board, however, does not have to reach the issue of the knowledge and skill required to directly supervise an MRI scan because the Board has concluded that (d) (3) does not apply to in-office referrals.

(ii) Provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and

(iii) Billed by:

(1) The health care practitioner performing or supervising the services; or
(2) A group practice of which the health care practitioner performing or supervising the services is a member.

§1-302(d)(4).

(1) "In-office ancillary services" means those basic health care services and tests routinely performed in the office of one or more health care practitioners. (2) Except for a radiologist group practice or an office consisting solely of one or more radiologists, "in-office ancillary services does not include: (i) Magnetic resonance imaging services; (ii) Radiation therapy services; or (iii) Computer tomography scan services.

H.O. §1-301(k)

Significantly for this case, exception (d) (4) by definition does not include MRI, CAT scan or radiation therapy services. Thus, no detailed analysis of (d)(4) is needed except possibly to shed light on the meaning of all three of the exceptions when read together. The first and most obvious consideration is that the legislature's clear language excluding self-referred MRIs from being exempted under (d)(4) makes it highly improbable that the legislature simultaneously intended to permit the same self-referred MRIs under (d)(2) or (d)(3). In this statutory context, an overly broad reading of (d)(2) or (d)(3) so as to make them overrule (d)(4) would make no common sense. The second consideration is that (d)(4) appears to round out the legislature's scheme of three discrete but meaningful exceptions.

Unlike (d)(2), which does not deal with "services or tests" at all, and (d)(3), which deals with "services or tests" referred to outside entities, the exception in (d)(4) was intended to create an exception for referrals for "services or tests" within the referring practitioner's practice. The Board finds that "in-office" means within the practice. Exception (d)(4) is thus the only exception for referrals for "services or tests" within the referring physician's practice. If a referral is for a "service" or "test" and is made in-office, it must meet the requirements of (d) (4). This result follows logically from the discussion above, in which the Board analyzed exceptions (d) (2) and (d) (3) and found that neither of them dealt with "services" or "tests" performed in-office. The three provisions apply to discrete situations and provide limited but meaningful exceptions without contradicting each other or violating the legislative intent. [17]

Exceptions (d)(2), (d)(3) and (d)(4): Summary of Findings

The Board concludes that § 1-302 (d)(2), (d)(3) and (d)(4) were intended to apply in separate and distinct factual scenarios. Exception (d)(2) was intended to cover referrals "of a patient" within a group practice. Exception (d)(3) was intended to cover referrals for "services or tests" to an entity that is outside of the referring physician's practice.[18] Exception (d)(4) was intended to cover referrals made for "services and tests" that are "basic," "routine" and rendered within the referring physician's practice, but not including MRIs. Read together, these exceptions are narrow and meaningful, do not overlap or contradict each other, and are consistent with the legislature's intent of

[17] This conclusion relates only to exceptions (d)(2), (d)(3) and (d)(4). A health care practitioner may fulfill the requirements of an exception that is beyond the scope of this discussion.
[18] In this declaratory ruling, the Board is using the term "referring physician's practice" to mean the practice at which the referring physician is practicing when that physician makes a referral – in other words, the practice to which the patient came prior to receiving the questioned referral.

permitting exceptions only when the danger of overutilization is small.[19] This conclusion is the same as that reached by the Attorney General. *See* 89 Op. Att'y Gen. 10 (2004) (referrals for MRIs to be performed on machines owned or leased by the referring practitioner's practice violate the Self Referral Law) and 91 Op. Att'y Gen. 49 (2006) (exception (d)(3) does not apply to in-office referrals).

Note on "Patient Convenience"

Some of the parties have argued that the purpose of some of the exceptions is "patient convenience." The Board has found nothing in the statute or the legislative history that indicates that these particular exceptions have that purpose. In addition, the staff has pointed out to the Board that none of the facts of this case indicate that patient convenience results from these self-referred MRIs. The Board notes that in not one of the example cases was an MRI conducted on the same day as the referral. In addition, it appears that a large percentage of the self-referred MRIs are performed in other geographic locations than the office in which the patient was first seen. For example, Multi-Specialty, according to the affidavit of one of its owners, has 18 offices in seven different counties, but only one MRI machine in one location. In general, many patients appear to be required to come back on a different day for their MRI, and a large percentage of them appear to be required to report to a different location to have the MRI. Although the Board has not studied this issue in detail, nothing in either the timing or the "spacing" of these MRIs would seem to be any more conducive to patient convenience than a non-self-referred MRI.

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[19] There have been no precedential court rulings on any self-referral issues. *See* 91 Op. Atty. Gen 49 (circuit court rulings not precedent) *and Maryland Patient Care and Access Coalition, et al. v. Board of Physicians* (Cir. Ct. Balto. City, Case No. 24-C-06-003146 OG) (ruling on motion to dismiss: circuit court does not have jurisdiction to issue a preemptive declaratory ruling because of the Board's statutory authority to issue an administrative declaratory ruling).

CONCLUSION

GENERAL FACT PATTERN

A patient is seen by an orthopaedic physician who has a beneficial financial interest in the orthopaedic practice. The patient may have been referred to the orthopaedist by another physician, or the patient may have come directly to the orthopaedic physician. The orthopaedic physician makes a referral for an MRI scan. The patient receives the MRI a few days or weeks later on an MRI machine that is owned and operated by, or leased by, the orthopaedic physician's practice. The MRI image may be read in-house or may be sent to an off-site radiologist to be read. An off-site radiologist may state his or her findings in a radiology report and forward the report back to the orthopaedic physician. The referring orthopaedic physician's practice submits a bill for the MRI as the provider of the MRI scan (though not necessarily as the provider of the interpretation of the scan).

The Board rules that any referral made under the **General Fact Pattern** set out above, unless it falls under another exception listed in §1-302 (d) that has not been considered in this case, is not exempted by exceptions (d) (2), (d) (3) or (d) (4) and constitutes an illegal self referral under the Maryland Self Referral Law.[20]

VARIATION 1

Same as the general fact pattern, but the orthopaedic physician obtains a signed Maryland Uniform Consultation Referral Form from the patient's primary care physician after the orthopedic physician determined that the MRI was necessary, but before the MRI was actually conducted.
The primary care physician does not, between the time that the orthopaedic physician determines that the MRI is necessary and the time that the MRI was accomplished, see the patient for the purpose of determining if the MRI is necessary, nor does he or she exercise independent medical judgment as to whether the MRI is appropriate or necessary.

The Board further rules that the fact pattern in **Variation 1** does not change this result. In Variation 1, a "non-invested" physician originally refers a patient to an orthopedic group practitioner who subsequently orders that MRI scan that is ultimately performed by his or her orthopedic practice. Between the time that the "invested" orthopedist orders the MRI and the time that the MRI is performed by his or her group,

[20] This ruling is intended to be a determination by the Board within the meaning of Md. Ins. Code Ann. § 15-111 (c).

the "non-invested" physician signs a Maryland Uniform Consultation Referral Form which authorizes this MRI for administrative purposes related to insurance and the patient's potential financial liability. The "non-invested" physician, however, neither sees the patient for the purpose of determining if this referral is necessary nor exercises medical judgment that the referral is necessary nor opines that the MRI should be performed at any particular facility. The Board concludes that to treat this pattern any different from the General Fact Pattern would be to elevate form over substance. Both the medical determination that the MRI is needed and the actual referral are both made by the "invested" orthopedist. This is a self-referral that violates the Maryland Self Referral Law.

VARIATION 2

> Same as the general fact pattern, but the orthopaedic physician names the primary care physician as the "referring physician" in the Health Insurance Claim Form.
>
> The primary care physician does not, between the time that the orthopaedic physician determines that the MRI is necessary and the time that the MRI was accomplished, see the patient for the purpose of determining if the MRI is necessary, nor does he or she exercise independent medical judgment as to whether the MRI is appropriate or necessary.

Variation 2 is not substantively different from Variation 1, and the Board reaches the same conclusion in that case also.

VARIATION 3

> Same as the general fact pattern, but a physician who is an employee of the medical practice that provides the MRI scan evaluates the patient and orders the MRI to be done by that practice. The physician-employee does not have any beneficial interest in the medical practice.

Variation 3, in which the referral is made by an employee physician, is a fact pattern that exists, as was made clear in the factual material submitted by Greater Chesapeake and Multi-Specialty. The Board is unable to make an all-encompassing

ruling on all cases in which the referring physician is an employee of the practice. Referrals for MRI scans by employee physicians may or may not violate the Self Referral Law, depending on the circumstances. First of all, an employee who is "directed" by an employer who is a beneficial owner to make the referral to the health care entity owned by the employer has made an illegal self-referral. §1-302 (a). In such a case, the referral is illegal, no matter what the content of the employment agreement or the contract. To this extent, **Variation 3** is no different than the General Fact Pattern, and the referral violates the Self Referral Law.

Also, if the referral is made according to an "arrangement" or "scheme" by which prohibited referrals are made indirectly, and which the referring physician knows or should know has as a principal purpose the making of otherwise prohibited referrals, the referral is illegal under the Self Referral Law. §1-302 (c). Such an arrangement or scheme could be established by many methods and office practices and could exist irrespective of the terms of the written employment contract. If such an arrangement or scheme does exist, the result would be no different than if the referral had been made under the General Fact Pattern, and the referral under **Variation 3** would violate the Self Referral Law.

If, however, an employee physician: (1) is not directed to make the referral; and (2) there is no arrangement or scheme by which self-referrals are accomplished; and (3) the employee physician is employed under a "bona fide employment agreement," then a referral to the employer's MRI facility under **Variation 3** does not violate the Maryland Self Referral Law. § 1-301 (c) (2) (ii). The Board interprets the term "bona fide

employment agreement" under this statute[21] as an otherwise valid employment agreement which by its terms does not require referrals to the employer's health care entity, which in practice does not require referrals to the employer's health care entity and under which no form of remuneration or compensation or favorable treatment is directly or indirectly tied to referrals to the employer's health care entity.

RULING

A referral by an orthopedic physician for an MRI to be performed on or by an MRI machine owned or leased by the orthopedic practice, insofar as that referral meets the criteria set out in the **General Fact Pattern**, or **Variation 1** or **Variation 2**, is an illegal self-referral within the meaning of the Maryland Self Referral Law. The exceptions set out in § 1-302 (d) (2), (3) or (4), argued in this case, do not exempt these tests from the general prohibition of the Maryland Self Referral Law. This Declaratory Ruling constitutes a "determination" within Md. Ins. Code Ann. § 15-111 (c).[22]

With respect to employee physicians, **Variation 3** is an illegal self-referral within the meaning of the Maryland Self Referral Law if the employee is directed to make the referral, or if there is an arrangement or scheme by which these referrals are accomplished, or if the employment is other than through a bona fide contract of employment as defined above by the Board.[23]

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[21] The term "bona fide employment agreement" should be interpreted consistent with the overall purpose of the Maryland Self Referral Law.

[22] Greater Chesapeake and Multi-Specialty have raised contractual defenses concerning the bills that the insurance companies have paid for these services. These defenses include estoppel and the statute of limitations. The Board, however, has no jurisdiction over any contractual dispute that may arise between the parties. The Board's only role is to determine the legality under the Self Referral Law and the Maryland Insurance Code of the underlying referrals.

[23] This Declaratory Ruling does not reach the issue of compensation arrangements under §1-301(c)(2)(iii),(iv) or (v), nor does it reach the exceptions listed in §1-302(d)(1) or (d)(5) through(d)(11).

The Board notes, however, that the statute is complex and difficult to interpret. The statute has been in effect since 1993, yet until 2004 the Board took no enforcement action on any self-referral issue and did not make any declaratory rulings on any self-referral issue. It was also not until 2004 that the Attorney General's first opinion on the issues directly raised in this case was issued. *See* 89 Op. Att'y Gen 10 (2004). There has thus been until relatively recently very little guidance as to the meaning of this complex law, and the Board has not until relatively recently been proactively offering such guidance. For these reasons, the Board will not take any disciplinary action under Md. Health Occ. Code Ann. §1-306 against any physician, for self-referrals ruled illegal under this ruling, based on any referrals made prior to the date of this Declaratory Ruling.[24]

The Board obviously has no jurisdiction over any civil actions that might arise between the parties as a result of self-referrals determined to be illegal under this ruling, and the Board does not presume to offer advice to a court or to the parties on the defenses of estoppel and statute of limitations that may be raised in any such litigation. For the record, however, the Board notes its own long history of non-enforcement of the statute until 2004, as set out above.

12/20/06
Date

Carol Samuels-Botts, M.D.
Vice Chair

NOTICE OF RIGHT TO APPEAL TO COURT

[24] This statement has no effect on the one self-referral disciplinary case which has already proceeded to disposition by Consent Order.

Any party to this Declaratory Ruling Procedure who is dissatisfied with the final ruling of the Board is entitled to appeal the ruling to the circuit court under Md. State Gov't Code Ann. § 10-305 (c).